## Policy Regarding Appointments

*Appointment Information*

Appointments are generally scheduled for 50 minutes in duration.

**In the event of inclement weather or an imminent threat thereof in North AL, please contact us before coming in to a scheduled appointment to make sure the office will remain open.**

Cancellations and Missed Appointments

Please understand that when you schedule an appointment, that hour is reserved for you and unavailable to anyone else. If you miss an appointment or cancel an appointment without providing a 24 hour notice (one business day), you will be charged a $50 fee. These fees are not covered by insurance.

Please note that appointment reminders from us (usually by email) are a courtesy. You will still be responsible for missed appointments and late cancellation fees even if you do not receive a reminder from us.

*Payment*

Payment for session fees are due at the beginning of each session along with any balance on your account.

Services may not be rendered or scheduled if there is balance on your account. Clients are expected to maintain a zero balance on their account.

*Agreement*

"My signature below indicates that I understand and agree to abide by the above stated policies regarding appointments with Reflections & Wellness Counseling, LLC."

_____ _____ _____

Signature of Client (or Parent if client is under age 14) Date Printed Name of Client

## *Policy Regarding Confidentiality, Contact and Consent for Services*

*Confidentiality*

In general, information shared in counseling is kept confidential and only released with the client's written consent. However, there are situations in which I am permitted or required by law to release private information to appropriate persons/authorities without consent. Situations include but are not limited to: if I believe there is a threat of harm to the client or another person; if I believe that physical/sexual abuse has occurred; if I receive a court order; if information is required for me to defend myself in event of lawsuit; if information is required to collect payment; and if a medical provider has a legitimate need for information to provide competent care. For more information regarding privacy, please refer to the Notice of Privacy Practices available upon request.

## Contact and Emergencies

You can reach me by phone at (256) 286-0071. If I am unavailable to answer, please leave a message, and I will return your call at my first available opportunity. Phone calls (non-administrative in content) may be billed at the usual rate ($40 hourly). These fees are not covered by insurance, and you will be financially responsible.

You can reach me by email at Shannon@reflectionswellnesscounseling.org. Please be advised that I cannot be held responsible for breaches in confidentiality that may occur in the electric transmission of information to/from Reflections & Wellness Counseling, LLC.

**If you experience an emergency during or after hours, please immediately call 911 or go to your nearest emergency room. Please be advised that I do not provide 24 hour assistance.**

Agreement and Consent for Treatment

"My signature below indicates that I understand and agree to abide by the above stated policies regarding appointments with Reflections & Wellness Counseling, LLC. I have received or been made available a copy of the Notice of Privacy Practices for Reflections & Wellness Counseling. Furthermore, I agree to receive counseling services from Shannon Allen, LPC. If my child (under age 14) is the client, I affirm that I am the guardian with legal right to consent to treatment for my child and I give my consent to Shannon Allen, LPC to provide counseling services to my child."

_____ _____ _____

Signature of Client (or Parent if client is under age 14) Date Printed Name of Client

Policy Regarding Fees, Payment and Insurance

*FEES* The standard fee for initial sessions and regular sessions (50 min) is $60. Sessions that last longer will be billed based on a pro-rated amount of $65 per hour, unless otherwise specified differently.

The fee for missed appointments and cancellations not made within 24 hours is $50. These fees are not covered by insurance and due no later than the beginning of the following session. The fee for insufficient checks is $35.

*PAYMENT* Session fees along with any balance on your account is due at the beginning of each session. If payment is not made in full, the session may be cancelled and you will be charged a missed appointment fee. Payments may be made by cash, check or credit card.

Clients are expected to maintain a zero balance. A zero balance is required before services are rendered or scheduled. Balances that have not paid within 90 days may be sent to a collection agency. If collections proceedings become necessary, you will be required to pay all related costs.

*AGREEMENT*

"My signature below indicates that I agree to abide by the policies stated above. I authorize release of information to any insurance company or paying entity for all claims and permit a copy of this authorization to be used in place of the original. I request payment of medical insurance benefits to the parties who accept assignment.

_____ _____ _____

Signature of Financially Responsible Party Date Printed Name

COUNSELING AGREEMENT & CONSENT FOR TREATMENT My signature below indicates my understanding and agreement of the following:

It is not my practice to participate in court proceedings. I believe in the rights of each person I work with and do not participate in court proceedings due to this

**I have received a copy of the Information for New Clients and Notice of Privacy Practices and agree to abide by the policies stated therein. ** I agree not to voluntarily involve Shannon Allen in any legal matters or proceedings. **I understand that all fees are due at the time of service, and I am responsible for late cancellation and no-show fees if I do not provide a 24 hour notice by phone. **If using insurance, I authorize Shannon Allen to release information related to my care including financial and medical data to my insurance company or any organization contracting with my insurance company that may be necessary now or in future for purposes of treatment, payment, or healthcare operations. I understand that a mental health diagnosis will be submitted to my insurance company. I am responsible for my co-pay, unmet deductibles, fees for services not covered by insurance and all fees that are not paid by my insurance company for any reason for more than 90 days.

**I understand that Shannon Allen does not provide 24-hour assistance and in an emergency, I should seek help immediately by calling 911 or going to the nearest Emergency Room. I authorize Shannon Allen to contact my Emergency Contact listed above if needed. **I agree to enter therapy and give my consent to Shannon Allen to provide me with counseling services.

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Signature of Responsible Party  Todays Date  Printed Name of Client